MDR Tracking Number: M5-04-1362-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on January 15, 04.

Based on correspondence from the requestor, ___, dated, 10-07-04, the date of service 04-16-03 for CPT code 99213 has been withdrawn from Medical Dispute Resolution and will not be addressed in this review.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The supplies and materials, massage therapy, range of motion measurements, myofascial release, therapeutic exercises, therapeutic procedures, and office visits from 02-17-03 through 06-10-03 were found to be medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 03-09-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
03-14-03	97110 (6 units)	$210.00	$35.00	F	$35.00 x 6	1996 MFG	See rationale below for 97110.
04-16-03	99213	$50.00	$0.00	R	$48.00	1996 MFG	Review of the TWCC database confirms that the compensability issues raised by the carrier have been resolved. Therefore, this disputed service will be reviewed in

							accordance with the 1996 Medical Fee Guidelines. Recommend reimbursement of $48.00.
06-10-03	97750 (4 units)	$172.00	$129.00	F	$43.00 x 4	1996 MFG	The requestor submitted relevant information to support services billed. Therefore, the service in dispute will be reviewed in accordance to the 1996 Medical Fee Guidelines. Recommend additional reimbursement of $43.00.
TOTAL		$432.00	$164.00				The requestor is entitled to reimbursement of $91.00.

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 02-17-03 through 06-10-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 15th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

March 4, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-1362-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

REVIEWER'S REPORT

Information Provided for Review:
Correspondence and Plan documentation
H&P and office notes
Daily progress notes
Therapeutic procedure notes
Rand of Motion Assessment
Radiology report

Clinical History:
This claimant injured his low back in a work-related accident on ___. He did not think it was significant, so he continued working for the next 3 days until he sought medical attention. The records provided indicated that he responded well to the treatment, even though it was slow.

Disputed Services:
Supplies and materials, massage therapy, range of motion measurements, myofascial release therapeutic exercises, therapeutic procedures, and office visits during the period of 02/17/03 through 06/10/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment, therapies, and services in dispute as stated were medically necessary in this case.

Rationale:
The ice pack and the analgesic balm, which were prescribed on February 17th are reasonable to the treatment of this diagnosis and are a common remedy to acute pain, especially at home. The office visits, range of motion, muscle testing, and performance testing are also necessary to monitor the patient's progress so the treatment plan can be adjusted accordingly. The therapeutic exercises were consistent and medically necessary for this diagnosis and for the patient's complete recovery.